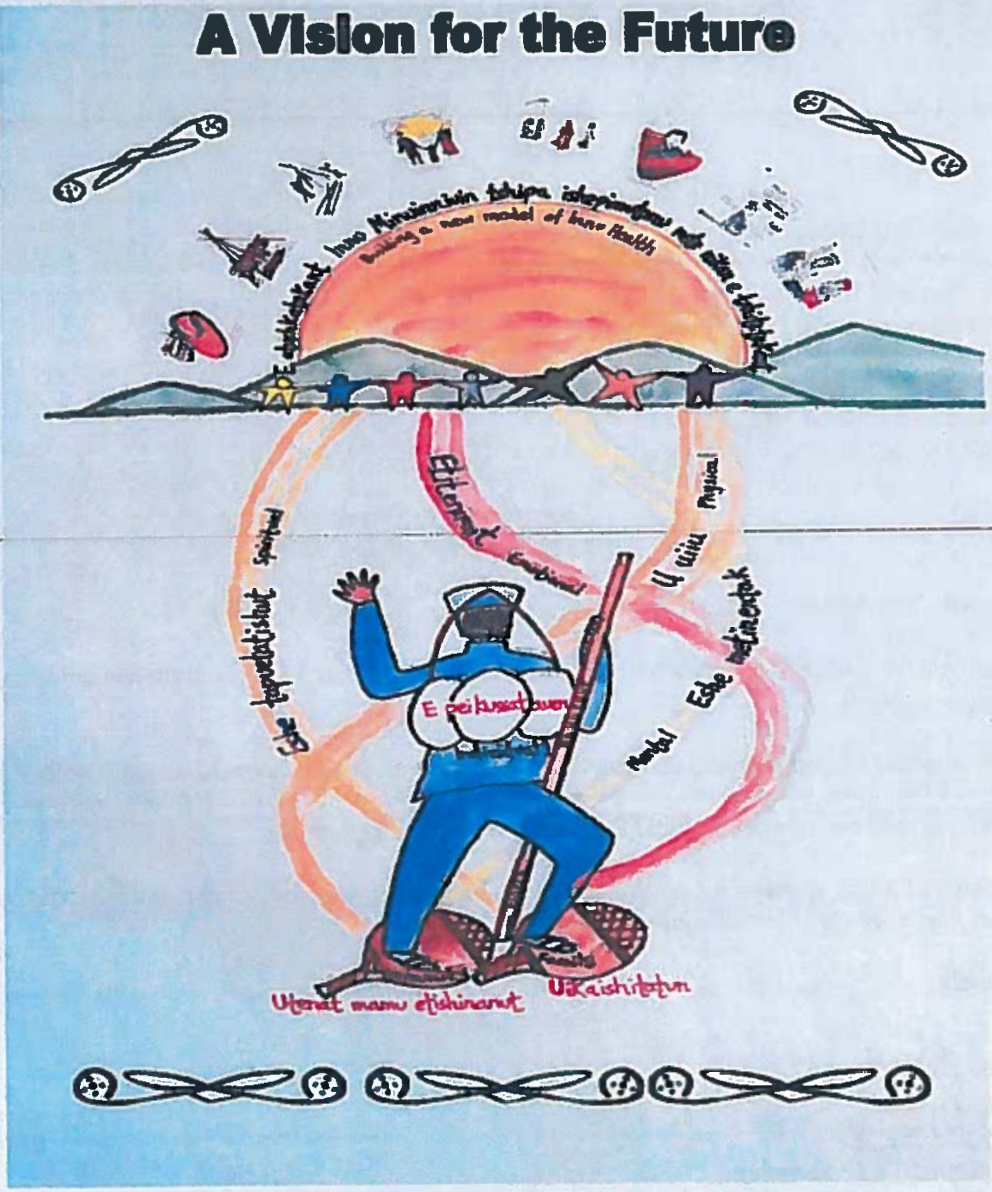
Developing an Innu Diabetes Strategy
A Vision for the Future



Proposal Submission to the Health Services Integration Fund
February 10, 2017
by the Innu Round Table Secretariat

c/o Sheshatshiu Innu First Nation, PO Box 160
Sheshatshiu, NL A0P 1M0
Ph: (709) 497-3854
Fax: (709) 497-3881

February 9, 2017

Ms. Kate Gray Mews
Policy Advisor, Policy and Strategic Planning
HSIF Regional Coordinator
First Nation and Inuit Health Atlantic
Suite 1525, Maritime Centre
1505 Barrington Street
Halifax, Nova Scotia B3J 3Y6
Email: kate.graymews@hc-sc.gc.ca

Re: Project Proposal
Health Services Integration Fund

Dear Ms. Gray Mews:

Thank you for feedback from our letter of intent to the above noted fund, and the invitation to submit a proposal.

Please find our project proposal funding for "Developing an Innu Diabetes Strategy", with support letters from our partners. Please note that although we have listed Health Canada as one of our partners, it is not protocol for them to supply a support letter.

Thank you for this opportunity, and we look forward to your response. If you or the Advisory Committee have questions or concerns, please feel free to contact me.

Sincerely,

Natasha Hurley
Executive Director
Innu Round Table Secretariat

cc: Jack Penashue, SIFN Social Health Director
Mary Pia Benuen, SIFN Primary Health Director
Kathleen Benuen, MIFN Health Director
Annie Picard, IRT Sec. Health Coordinator

Table of Contents

A Future Where...

....every Innu Citizen walks along their own diabetes journey with balance and cultural dignity, with their spiritual, emotional, physical and mental health being well. Living a healthy life with diabetes, free of illness and complication, requires taking care of all components of self. Self-management of diabetes requires acceptance, inner-strength, love and forgiving.

Personal Journey Self-Management

Family, Community and System Supports

.... family and community provide support and grounding. Services, medical and social supports offered by internal and external partners, are in place, integrated, and respectful of Innu Culture, Health Beliefs and Way of Life. Innu Traditional Knowledge, Foods, and Practices are encouraged, alongside the knowledge and experience of the Western Medical Model guidelines and approaches, for diabetes management and prevention.

... there are a variety of services and programs relevant to each Innu individual, family and group; there is better access to services; there are better individual and community outcomes; and there is less illness of community members due to poor diabetes control.

Mushuau Innu | Innu First Nation | Innu Round Table Secretariat | Innu Mikmaq Diabetes Initiative | Labrador Grenfell Health | Health Canada

A2. Recipient

Name of Organization: Innu Round Table Secretariat
Address: PO Box 160, c/o Sheshatshiu Innu First Nation, Labrador A0P 1M0
Contact Name: Natasha Hurley
Title: Executive Director
Telephone: 709-497-3855 ext. 232
Fax: 709-497-3881
e-mail: nhurley@irtsec.ca

A3. List of Key Partnering Organizations
Mushuau and Sheshatshiu Innu First Nations
Labrador Grenfell Health Authority
Health Canada

A4. Funding Requested

Funding Requested from HSIF (by fiscal year):	2017-18 -- $127,340 2018-19 -- $ 57,700	
Other Funding Sources and Amounts: IRT Sec	2016-17 -- $ 39,000	
Total Project Budget (by fiscal year):	2016-17 -- $ 39,000 2017-18 -- $127,340 2018-19 -- $ 57,700	$185,040

A5. Duration of Project
18 – 24 months from start date

A6. Overall Objective(s) of the Project
The overall objective of this project is to facilitate discussions and meetings that will provide opportunities for all stakeholders to give input, knowledge, experience and expertise, from their personal and professional perspectives.
The far-reaching, overall goals are:
from the users' point of view – to meet individual and community needs, resulting in better health outcomes, and reduce rates of ill-health and un-wellness of community members, and the community at large,
from the providers' point of view – to better coordinate existing services, providing efficient and effect health services,
from the leaderships' point of view – to provide Innu relevant services.
The focus will be on bringing the existing community, provincial and federal partners together to identify best practices, discuss how to better coordinate their collective services and

Project Proposal to the Health Services Integration Fund

Section A: General Information

A1. Project Title
Developing an Innu Diabetes Strategy

Summary:
This proposal is to request funding to retain a Project Coordinator, to carry out project objectives and activities, as detailed in part B of this document, and to cove associated costs.

The roles and responsibilities of the Project Coordinator will be to:
a) organize and conduct individual interviews, group sessions, focus groups and facilitated meetings with the "stakeholders":

- **service users - Innu community members of Sheshatshiu and Mushuau Innu First Nations;**
- **service providers - community, provincial and federal partners, related to diabetes prevention and management, and,**
- **community leaders - elected representatives,**

to gather information that will provide a clear understanding of the details that are contributing to the high level of uncontrolled diabetes in both communities, the deficiencies in the system of care that is currently being offered, and provide community input;

b) use the information gathered from the interviews and meetings to aid in the designing of a Innu Diabetes Strategy and a new service delivery model for diabetes management and prevention for the Labrador Innu. The design will ensure individuality and continuity of care for diabetes education, clinical management, and self-management education and support, whilst observing current best practices, policies and procedures, and clinical practice guidelines, from both mainstream and Indigenous approaches;

c) ensure activities of the project are sanctioned by, and reported to, the Project Steering committee on a monthly basis, and

d) aid the stakeholders/partners in implementing and assessing the new diabetes management and prevention model of care.

- by reviewing local, regional, provincial, national and indigenous strategies addressing diabetes;
- by examining other best and promising practices and programs currently being delivered;
- by collecting health information and medical data on community members diagnosed with type 2 diabetes, pre-diabetes, and gestational diabetes, and
- by interviewing community members and other relevant stakeholders and partners;

we will build an Innu Diabetes Strategy and "identify a new service delivery model that is sensitive to Innu culture and the realities experienced by Innu with diabetes", (IRT project description, 2016)

B2. Project Description

- The proposed project addresses recommendations from the Diabetes Assessment Project conducted in 2014-15. Specifically the situation now is that there are numerous challenges, which are identified by the majority of people that were interviewed. These challenges continue to hinder the effective use of time and energies of diabetes health service providers. The Report referred to conversations dealing with situations such as, but certainly not limited to, continuous no-shows for booked appointments, uncertainties of the effectiveness of the diabetes education delivered, and a lack of personnel to aptly deal with these challenges. Innu people with diabetes spoke frankly and openly about the "inappropriateness" of the current model of care, and a desire to have input into how such services could be re-designed to better meet their needs

- This issue has been identified as a priority by the Diabetes Assessment Project, (and the response from the Innu Round Table to move forward on the issue of re-designing a new model of care), and the Innu Healing Strategy of April 2014. Data obtained from various health and health needs assessments conducted in the recent past indicate a high and continuously rising rate of diabetes in both communities, and a high rate of complications.

- This project will result in changing the picture of diabetes services for the Innu of Labrador. Currently the picture is one of limited services, that have minimal coordination, (despite the efforts and partnering of front line staff delivering the services) resulting in a system that is inefficient and ineffective in meeting individuals' needs for diabetes education and support. There will be better access to services and more appropriate and culturally relevant services. Services will have more uptake, there will be better access to services, more varied services will be offered, and there will be a reduction of no-shows to clinical educational appointments. This will result in better individual and community health outcomes related to diabetes. There will be less illness due to poor diabetes control.

resources, and develop an integrated, interdisciplinary model of service delivery for diabetes prevention and management.

Section B: Project Information

B1. Executive Summary

A Diabetes Assessment for the Innu of Labrador was performed during the Fall and Winter of 2014-15. Numerous questionnaires, focus groups, and interviews were conducted with community members, some with diabetes, some without, internal and external health partners, and community departments. The consultant of the assessment used the Expanded Chronic Care Model, a model adopted by the Canadian Diabetes Association as the gold standard for the design and delivery of diabetes programming and services, as a framework for data collection design and implementation, for analyzing data, and for the development of the recommendations. As such, our project will continue to use the Expanded Chronic Care Model as a framework, advancing the conversations started during the Assessment and lead to acting upon the recommendations. (The report was distributed widely upon its completion in April 2015, and continues to be available for downloading from the IRT website or in printed form.)
Data from the project revealed that the current design and delivery of diabetes management and prevention services does not appropriately address the identified needs and barriers that Innu who are diagnosed with diabetes experience. The report states that "Regular consultation with Innu who have diabetes is important to ensure that diabetes services and programming remain relevant to the evolving needs of Innu. Reorienting diabetes programming and services needs to involve a collaborative approach between health partners and community departments and employers; a coordinated approach to diabetes management and prevention services will help to create supportive social and physical environments for Innu of all ages", Diabetes Assessment report p. 39-40
After extensive review of the information and recommendations of the Diabetes Assessment Project by the Diabetes Wellness Working Group, a sub- committee of the of Innu Minuinniun Committee (IMC), the Group wrote an Analysis and Management Action Plan. The plan was presented to, and subsequently supported by, the IMC. It was later presented to the Innu Round Table (IRT), the tripartite forum of senior level officials of the Innu and the Provincial and Federal governments. The response from the IRT was a consensus to support the first two recommendations, particularly the ones that required direction from higher level decision makers, and to move forward with the development of an Innu Diabetes Strategy, including a new services delivery model.

Our proposed project, by building on knowledge gained through:

- the Diabetes Assessment Project, as noted above,
- the Innu Healing Strategy,
- the Expressing Innu Health Knowledge workshop,
- the Innu Health Needs Assessment Report, and
- Innu related Health Information/Data Management and Health Capacity needs reports; and,

Weather has impacted negatively on planned meetings, and events. These factors result in an elevated risk that some proposed activities might get postponed. Therefore, the timelines for this project have been lengthened to cover an overall period of 18 – 24 months, allowing for a high level of flexibility if the project is stalled or delayed due to unforeseeable circumstance.

- Increased access to diabetes management and prevention services will be measured through comparison data on the rates of participation of the services offered. Currently there is a high no-show rate for diabetes education appointments, with varied levels of satisfaction about these services. There is reported to be a high rate of uncontrolled diabetes, a risk factor for long-term complications. The approach that will be taken to measuring increased access to, and the quality of services as a result of the project will be a comparison of the baseline qualitative and quantitative data to the same data 6 – 9 months subsequent to the implementation of the new model of care.
- The proposed project would be sustained by the Project Coordinator, with an adherence to objectives, activities and timeframes. Any projected new operational or infrastructure costs that will be needed to sustain the proposed integration arrangement, or process, will be included in the budgetary forecasts of the 3 options that will be presented to the Innu Round Table for their consideration.

B3. Work Plan
Attached – Appendix A

B4. Budget

- All partners have offered concrete, informed support for this proposed project. The response of the Innu Round Table in February of 2016, signifies support from senior/executive, management and leadership levels. Letters of support have been received, (attached), and there is full participation on the Project Steering Committees, including the Community Diabetes Workers of both communities, Labrador Grenfell Health (LGH) Diabetes Nurse Educator and/or Dietitian, and LGH Regional Nurses. There have been numerous positive conversations about the project with Innu community members which has resulted in a high level of interest shown for participation as key informants for the proposed interviews and focus groups

- Capacity and readiness of the partnering organizations of this project is considered to be substantial. Partnering organization's personnel have extensive knowledge of diabetes management and prevention, from their own perspectives, whether they be front line workers, managers, or policy makers. This provides a high level of capacity to carrying out the specific operational tasks of their own specific roles of the project. Readiness has been demonstrated in a number of ways. A Steering Committee for the project is already in place, being established during the preparatory and surveillance stages of the project. The Committee has representation from all partners, as outlined in the Terms of Reference, and there have actually been requests from Labrador Grenfell nursing staff at the Mani-Ashini Health Clinic to participate on the committee.
  Experience comes from personnel at various levels. Front-line staff experience the everyday challenges of providing a service to meet the needs of a population whose members are at different places of readiness of taking on the, sometimes overwhelming tasks needed for self-managing their diabetes. Staff in management positions are cognizant of budgetary considerations that impact on the quantity of services that their organization can provide. Senior level decision makers who sit on the IRT must decide how to best balance budget and services
  It is anticipated that the current project lead will continue in the role, becoming the Project Coordinator, if the project is funded. She has expertise in diabetes, and experience working in the Innu communities for the past 6 years. During that period of time, she has worked with all the partners that will be involved with this project. She has built rapport and trust with the Innu communities, and is well known to community members, health staff of both the bands, LGH and Health Canada. She has experience in program and project management and has been acutely aware of the necessity to collaborate and integrate diabetes management and prevention services that have been provided through different governmental funding bodies.
  We are fortunate to have this enormous amount of diversity of experience, expertise and responsibility, of all partnering personnel engaged in the project. This will ensure that the options for a new delivery model contain all the components that are important and relevant for each partnering organization.

- The key challenges will be to follow timelines. Due to the nature of the lives of key informants, whether they be community members, or staff from partnering organizations, it is our experience that "things" take longer in this region of Canada.

Appendix A - Work Plan
Developing an Innu Diabetes Strategy

This work plan provides details on how the proposed project will build on and advance the current work of the IRT Secretariat project, of which the first two phases are nearing completion. Phase 1: the preparatory phase was the development of the framework and parameters for the project, communicating project goals and objectives to community and its members and partners; and, recruitment of key informants to participate in interviews and focus groups. During this phase a Project Steering Committee was established and Terms of Reference were sanctioned by the Committee. It is anticipated that by early March of 2017, two Innu Project Assistants, one in each community, will be in place to provide Innu-Aimun interpretation and translation during interviews and focus group discussions. Phase 2: the literature review phase involved the surveillance and review of current and relevant research, guidelines, health care delivery models (mainstream and indigenous approaches), assessment tools, reports, and diabetes programming models, to: a) determine appropriate data and information to collect from key informants, and develop data collection tools for the project and; 2) to serve as relevant considerations for design options for the proposed new diabetes care service delivery model (a component of the Innu Diabetes Strategy).

To advance the above noted work, the key functional areas are defined as:

1) Data Collection
2) Organization, Interpretation, and Analysis of Data
3) Design and Writing of Strategy
4) Design and Writing of Service Delivery Model Options
5) Decision on New Model
6) Implementation of New Delivery Model
7) Assessment of New Delivery Model

Timelines

Functional Area	Months – after project funding approved.																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1) Data Collection																		
Interviews & Focus Groups																		
Facilitated Meetings																		
2) Data Analysis																		
3) Strategy Development																		
4) Delivery Model Options Development																		
5) Presentation of Models to IRT																		
6) Implementation of New Model																		
7) Assessment of New Model																		
	and beyond if necessary, up to 24 months >>>>>>																	

Cost Category	Fiscal Year 2017-18	Fiscal Year 2018-19	Total
Personnel			
One Project Co-ordinator/Consultant per diem $700	75 days	50 days	
(for all functional areas)	$52,500	$35,000	$87,500
Two Project Assistants per diem $200	47 days	38 days	
(for data collection, data analysis, meetings)	9,400	7,600	17,000
Steering Committee per diems $450/meeting	16 meetings	8 meetings	
(1 meeting each community/month excluding	7,200	3,600	10,800
summer, Christmas, Easter break – estimate 24)	$69,100	$46,200	$115,300
Supplies & Services			
Two 2 Day Symposiums (one in each community)			
Meeting Rooms - $250/day	1,000		1,000
Catering - $75/person/day (100 people)	30,000		30,000
Additional remuneration for staffing, and speakers	4,640		4,640
	35,640		35,640
Professional Fees			
Elders' Consultation	4,000		4,000
Travel & Accommodation	4 trips	3 trips	
Project Coordinator - trips to Labrador @ $3,500/trip	14,000	10,500	24,500
(Air fare, accommodation, meals)			
Equipment & Office Rental Cost – N/A			
Communication & Dissemination			
Photocopies & Materials	1,000	1,000	2,000
Training & Staff Development			
Project Assistants – 2 day training/community	3,600		3,600
Other – N/A			
Total	$127,340	57,700	$185,040

Objective	Activities	Outputs	Timelines	Lead/Partners
1.5 To facilitate the sharing of best practices, both mainstream and indigenous approaches, and conventional and indigenous models of care. To brainstorm and explore ways to better coordinate existing resources and services.	Plan and implement facilitated focus groups and break-out sessions during a two day diabetes symposium (in each community) of community members, leaders and elders, and community, provincial and federal service providers.	Knowledge sharing and transfer to explore priority features to be included in the strategy and new care delivery model options.	November, 2017 (Diabetes Month)	Project Coordinator Project Assistants Key Informants

2) Organization and Analysis of Data

Organize information and medical data gathered. Decipher and interpret data. Write synopses. Present Synopses to Steering Committee

Objective	Activities	Outputs	Timelines	Lead/Partners
2.1 To systematically organize data collected.	Gather, review, organize, interpret and analyze health information obtained through interview, and medical data obtained through chart reviews.	Summary of information organized into categories of emerging themes.	Months 5 through 8	Project Coordinator
2.2 To compare qualitative data obtained from client (perceived DM control) to medical data obtained from Meditec, CRMSA, and HCP's providing diabetes education and treatment.	Conduct comparative review, summarize, prepare report	Systematic analysis report of findings	Months 5 though 8	Project Coordinator
2.3 To communicate findings Steering Committee	Presentation to Steering Committee	Dissemination of findings to appropriate groups	Months 8 through 10	Project Coordinator

Details of Functional Areas of Work Plan:

1) Data Collection (Planning and Logistics)

Engage key informants, through individual and focus group sessions and meetings, to gather more detailed information in relation to the themes brought to the forefront during the Diabetes Assessment Project of 2014-15. Activities to collect information from key informants necessary to carry out the designing of a new diabetes management and prevention service delivery model.

Do a medical chart review of consenting DM individuals to compare perceived diabetes control to the five DM control indicators cited in the 2013 Clinical Practice Guidelines. Conduct DM client satisfaction surveys.

Objective	Activities	Outputs	Timelines	Lead/Partners
1.1 To recruit and retain a project coordinator/ consultant	IRT Sec Ex Director will engage in conversations with potential individual	Contract.	1 – 2 weeks subsequent to project funding	Lead: IRT Executive Director
1.2 To introduce project and participatory requirements to key informants, and acquire confidentiality and consent pledges for key DM informants.	Project Co-ordinator will contact key informants to set up information meeting(s).	Interviews, focus groups, and facilitated meetings scheduled to collect medical data and health information.	Months 1 through 6	Project Coordinator Project Assistants Key informants
1.3 To acquire baseline medical data and health information of DM, pre DM and gestational DM clients. Privacy and confidentiality is maintained throughout data collection phases.	Obtain memo/letter of understanding for sharing of health information and medical from custodians (LGH) Obtain permission from clients to collect baseline health indicators data through a chart review.	Anecdotal data obtained through client satisfaction surveys, readiness to change assessments, and self-management efficacy scales, using reliable and validated resources obtained during phases 1 & 2 of project. Medical data obtained through chart reviews and surveillance of LGH Meditech and CRMS	NB - Memo of Understanding is being sought regardless of approval of funding for this project. Months 1 through 6	LGH senior executives/Innu elected leaders & Health Directors. Project Coordinator Project Assistants Key DM Informants
1.4 To build on information collected from past reports, assessment, etc...) to identify challenges and inefficiencies of current diabetes services delivery model	Conduct interviews and/or focus group with DM clients. Conduct interviews and focus groups with service providers and other relevant program staff.	Qualitative and quantitative data. (Available for further discussions at facilitated meeting of the community, provincial and federal service providers.)	Months 1 through 6	Project Co-ordinator Project Assistants Key Informants

6) Implement New Service Delivery Model

Objective	Activities	Outputs	Timelines	Lead/Partners
6.1 To establish and get sanctioning of policies and procedures from all stakeholders	Write policies and procedures, job descriptions and job postings if relevant	Systems in place for new model of care	Months 12 through 18	Project Coordinator
6.2 To communicate new model of care to all stakeholders and partners	Hold information sessions and meetings with community members and health care providers	New Model of Care Communicated	Months 12 through 18	Project Coordinator
6.3 To assist in the implementation of the new care model	Provide one-on-one or group information sessions & training	New Model of Care Implemented	Months 12 through 18	Project Coordinator Health Care Providers of LGH & Innu Bands

7) Assess New Service Delivery Model

Compare baseline qualitative and quantitative data gathered at beginning of project (interviews and chart reviews) as baseline, compare to data collected 6, 9, or 12 months (depending on timing factors)

Objective	Activities	Outputs	Timelines	Lead/Partners
7.1 To obtain qualitative and quantitative data	Conduct interviews, focus groups, and gather medical data	Comparative data	Months 16 through 18 or up to 24	Project Coordinator Project Assistants Key Informants
7.2 To review baseline data and comparative data	Systematic review and comparisons of key indicators	Assessment of New Delivery Model	Months 16 through 18 or up to 24	Project Coordinator
7.3 To report on findings	Write Report and present to Communities and Stakeholders	Report	Months 16 though 18 or up to 24	Project Coordinator Stakeholders
7.4 To disseminate report to community at large	Copy and distribute report.	Community members and Stakeholders are confident New Delivery Model is efficient and effective, meeting the needs of the Innu	Months 16 though 18 or up to 24	Project Coordinator

3) Design, Write Strategy

The writing of the Innu Diabetes Strategy (visionary), with Action Plan (three options for consideration by the governmental partners that are members of the Innu Round Table.

Objective	Activities	Outputs	Timelines	Lead/Partners
3.1 To use the information gathered from research surveillance, data collection, and key informant interviews and meetings to design the proposed Innu Diabetes Strategy	Write Innu Diabetes Strategy	Innu Diabetes Strategy envisioned, conceptualized and written	Months 9 through 12	Project Coordinator Project Steering Committee
3.2 To present and request feedback on the Strategy from the Project Steering Committee for review, discussion and changes	Present draft Strategy to Steering Committee for review, revise	Revisions made as per feedback from Steering Committee	Months 9 through 12	Project Coordinator Steering Committee

4) Design, Write 3 Service Delivery Model Options

The "action plan" of the Innu Diabetes Strategy

Objective	Activities	Outputs	Timelines	Lead/Partners
4.1 To design 3 options for a new diabetes management and prevention delivery model, based all information gathered from key informants.	Writing of 3 Care Models	3 Options written	Months 11 & 12	Project Coordinator Steering Committee
4.2 To engage Steering Committee for their review	Present to Steering Committee at regular meeting	3 Options finalized	Months 11 and 12	Project Coordinator Steering Committee

5) Decision on New Service Delivery Model

Presentation to IRT for review and decisions

Objective	Activities	Outputs	Timelines	Lead/Partners
5.1 To achieve direction from the IRT on which model of care to sanction	Presentation of Strategy and the 3 options for a New Model of Diabetes Care	Innu Diabetes Strategy New Innu Specific Model of Care	Months 10 though 12	Project Coordinator IRT Secretariat IRT
5.2 To communicate decisions to all stakeholders	Prepare presentations, posters, pamphlets, radio announcements	Communication Strategy	Months 10 through 12	Project Coordinator Project Assistants

SHESHATSHIU COMMUNITY HEALTH DEPARTMENT
SHESHATSHIU INNU FIRST NATION

Mani Ashini Clinic
2 Shenum Street, PO Box 160
Sheshatshiu, NL A0P 1M0

Phone: (709) 497-8375 or 497-8423
Fax: (709) 497-8166

February 7, 2017

Ms. Natasha Hurley, Executive Director
Innu Round Table Secretariat
c/o Sheshatshiu Innu First Nation
PO Box 160
Sheshatshiu, NL A0P 1M0

Dear Ms. Hurley

Re: Developing an Innu Diabetes Strategy

I write on behalf of the Community Health Department of Sheshatshiu Innu First Nation in support of the Innu Round Table Secretariat proposal to the Health Services Integration Fund, for a grant to fund the Development an Innu Diabetes Strategy Project, which includes designing a new model of diabetes care for the Labrador Innu.

Diabetes was identified as a priority in the Innu Healing Strategy, and many of our primary health staff volunteered to participate in the Diabetes Assessment Project conducted by your organization in 2014-15. In accordance with the Innu Round Table directive of February 2016, the Primary Health Department support the advancement of developing an Innu Diabetes Strategy.

Through this letter, we acknowledge to supporting the project, in principle, and assisting with in-kind services such as providing space for meetings. We will also encourage staff to engage in interviews, and focus groups. Staff of our community diabetes program, the Innu Integrated Diabetes Initiative, have been involved with the initial stages of this project, and currently participate on the Steering Committee for the project. We also agree to having relevant staff attend facilitated meetings of all partners and engage in discussions regarding how the services currently being provided by each organization can be re-oriented, through collaboration, to best meet the needs of the Innu

The IRT Secretariat will take responsibility to lead the project, as proposed in your submission. This includes recruiting a project coordinator, conducting interviews and facilitated meetings with community members and staff of the partnering organizations, and giving updates on the projects activities to all partners on a regular basis.

We look forward to working with you in re-orienting diabetes programs and services to the needs of the Innu, sensitive to Innu culture and the realities experienced by Innu with diabetes.

Sincerely,

Mary Pia Benuen
Primary Health Care Director

Sheshatshiu Innu First Nation
Social Health Department
P.O. Box 160
Sheshatshiu, Labrador
A0P 1M0
Bus: (709) 497-8231
Fax: (709) 497-8973

February 7, 2017

Ms. Natasha Hurley, Executive Director
Innu Round Table Secretariat
c/o Sheshatshiu Innu First Nation
PO Box 160
Sheshatshiu, NL A0P 1M0

Dear Ms. Hurley

Re: Developing an Innu Diabetes Strategy

~~On behalf of the Sheshatshiu Innu First Nation Social Health Department I am writing this letter to show our~~ support for the "Developing an Innu Diabetes Strategy" Project, which includes designing a new model of diabetes care for the Labrador Innu.

As a community, we are concerned about the rising rates of diabetes in the past decade, and we can also see many of our people suffering from the long term complications caused by poor control of this disease. Our department is responsible for the Mental Health and Addictions (MHA) programming and service delivery in the community. We understand the complicated matter diabetes can become when someone is dealing with these types of issues, and are aware that there is a higher rate of depression in people living with diabetes. I would be most pleased to offer the knowledge and experience of our staff in discussions on how to integrate MHA programming into the Innu Diabetes Strategy, and new model of care.

Through this letter, we acknowledge to supporting the project, in principle, and assisting with in-kind services such as providing space for meetings. We will also encourage staff to engage in interviews, and focus groups. We also agree to having relevant staff attend facilitated meetings of all partners and engage in discussions regarding how the services currently being provided by each organization can be re-oriented, through collaboration, to best meet the needs of the Innu

As proposed in your submission, the IRT Secretariat will take responsibility to lead the project, and administer the finances. Objectives and work tasks are outlined in the details and work plan noted in the proposal.

We look forward to working with you in re-orienting diabetes programs and services to the needs of the Innu, sensitive to Innu culture and the realities experienced by Innu with diabetes.

Sincerely,

Jack Penashue BSW
Social Health Director

Mushuau Innu Health Commission
Tel: (709)478-8871/8891/8892
Fax: (709)478-8821

P.O Box 188,
Natuashish, NL
A0P 1A0

February 7, 2017

Ms. Natasha Hurley, Executive Director
Innu Round Table Secretariat
c/o Sheshatshiu Innu First Nation
PO Box 160
Sheshatshiu, NL A0P 1M0

Dear Ms. Hurley

Re: Developing an Innu Diabetes Strategy

On behalf of the Mushuau Innu First Nation Health Department I am writing in support of the Innu Round Table Secretariat proposal to the Health Services Integration Fund, for a grant to fund the "Developing an Innu Diabetes Strategy" Project, which includes designing a new model of diabetes care for the Labrador Innu.

As a community, and at the Health Commission, we are concerned about the rising rates of diabetes in the past decade, and perceive that there is also a high rate of uncontrolled diabetes in our community. Coupled with an increasing incidence of complications and their devastating effects, it was not surprising to those of us directly involved in health, that diabetes was identified as a priority in the Innu Healing Strategy. When the IRT Diabetes Assessment Project was conducted in 2014-15 our community members and health staff participated wholeheartedly. We are pleased to see this project move forward, and in accordance with the Innu Round Table directive of February 2016, our Health Department supports the advancement of developing an Innu Diabetes Strategy.

Through this letter, we acknowledge to supporting the project, in principle, and assisting with in-kind services such as providing space for meetings. We will also encourage staff to engage in interviews, and focus groups. Staff of our community diabetes program, the Innu Integrated Diabetes Initiative have been involved with the initial stages of this project, and currently participate on the Steering Committee for the project. We also agree to having relevant staff attend facilitated meetings of all partners and engage in discussions regarding how the services currently being provided by each organization can be re-oriented, through collaboration, to best meet the needs of the Innu

As proposed in your submission, the IRT Secretariat will take responsibility to lead the project, and administer the finances. Objectives and work tasks are outlined in the details and work plan noted in the proposal.

We look forward to working with you in re-orienting diabetes programs and services to the needs of the Innu, sensitive to Innu culture and the realities experienced by Innu with diabetes.

Sincerely,

Kathleen Benuen
Health Director

Appendix B - Letters of Support
Developing an Innu Diabetes Strategy